Report of an inspection of a Designated Centre for Disabilities (Adults)

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Newcastle West Community Residential Houses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Brothers of Charity Services Ireland</td>
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<tr>
<td>Address of centre:</td>
<td>Limerick</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>13 February 2018</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0004783</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0020978</td>
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</tbody>
</table>
About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The overall objective of the service is to provide care, support and services to residents on a full-time basis and a limited day service to one resident. Inspectors found that the service provided was as described in the statement of purpose.

The centre is comprised of two domestic-style properties located a short distance from each other and conveniently located to the day service and all of the amenities of a busy town. A total of nine residents are accommodated; four male residents live together in one house and five female residents live in the other house. Residents meet in the day service and socialise with each other at weekends if they choose to do so.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>30/11/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>9</td>
</tr>
</tbody>
</table>
How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. **Capacity and capability of the service:**

   This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. **Quality and safety of the service:**

   This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.
This inspection was carried out during the following times:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 February 2018</td>
<td>09:15hrs to 17:30hrs</td>
<td>Mary Moore</td>
<td>Lead</td>
</tr>
</tbody>
</table>
Views of people who use the service

Nine residents live in this designated centre on a full-time basis. Inspectors did not meet with the residents during this inspection. All of the residents attend structured day services and both houses were vacant during this inspection. Inspectors did however review records including complaint records, minutes of resident meetings and minutes of the review of residents’ personal plans to establish a sense of residents’ views of what it was like for them to live in this centre.

Capacity and capability

The inspection was carried out to monitor on-going compliance with regulatory requirements. Inspectors found that the centre was effectively governed and that there were systems for monitoring on a consistent basis the quality and safety of the service.

There was a clearly defined management structure and persons participating in the management of the centre were clear on their respective roles, responsibilities and reporting relationships. There was evidence that staff worked in a collaborative and supportive manner with each other, with families and with other services such as the day care service so as to ensure the continuity, quality and safety of the care and services provided to residents.

The person in charge was recruited to her role in March 2015. The person in charge worked full time, this was her substantive role and she was available in the centre five days per week including alternate weekends. Inspectors found that the person in charge had ready and sound knowledge of each resident and the support that they required to keep well and safe. It was clear to inspectors that the person in charge had good oversight of the service and was consistently engaged in the governance, operational management and administration of the designated centre.

The person in charge had ready access to the area manager and regular meetings ensured that information on the service was effectively communicated. For example the person in charge convened team meetings in the centre, the person in charge met with the area manager and they both met regularly with the representative of the provider. This ensured that issues that could not be resolved locally were appropriately escalated.

There were effective systems for the review of quality and safety. The person in charge completed periodic reviews of resident’s personal plans and quarterly audits of medicines management. Both the unannounced visits and the annual review as
required by Regulation 23 (1) (d) and 23 (2) were undertaken. Reports and action plans issued from each visit and were available for the purpose of inspection; the reviews incorporated consultation with staff, residents and their families.

Each review followed up on and validated the implementation of the previous action plan. Overall while actions did issue consistent good practice was evidenced and positive feedback was provided to the reviewer by those consulted with.

Ordinarily there was one staff present in each house and the night time staffing was a sleepover arrangement. There was a core group of regular staff; relief staff though regularly employed were sourced from the providers own local services so as to provide continuity for residents.

There was evidence that staffing numbers and arrangements were appropriate to residents needs, for example, the internal review completed in November 2017 had identified no staffing issue; this included feedback from a staff and resident spoken with. However, records seen, that is, risk assessments and residents' personal plans raised queries as to the adequacy of staffing. Inspectors requested clarity and assurance from the provider as to the appropriateness of staffing numbers and arrangements. This assurance was received following the inspection and was accepted from a perspective of risk and resident safety by inspectors.

However, a resident’s personal plan had also identified a priority for one-to-one staff time to support community access and meaningful engagement. It was unclear how often this one-to-one time was available to the resident or if the allocated time was adequate to support the resident in achieving their personal objectives and personal development. There was an associated risk assessment for inadequate one-to-one time; the risk scoring fluctuated and was most recently assessed and rated in December 2017 as of moderate risk.

The person in charge completed formal supervisions with staff. In addition, the person in charge monitored the care and supports delivered to residents and the records maintained by staff of such care and support. Further supervision was facilitated by regular staff meetings; these meetings facilitated staff to raise any concerns or issues that they may have had about the quality and safety of the care and support provided.

Records were maintained of the training completed by staff. Inspectors reviewed these records and saw that staff had completed safeguarding, fire safety and manual handling training and training in de-escalation and intervention techniques in response to behaviours of concern.

However, all staff had not completed the safe administration of medicines training prior to commencing work in the centre. While inspectors were advised that all staff had completed training in the administration of a medicine required in response to a specific emergency, records to this effect were not maintained for all staff.

The person in charge was seen to maintain a copy of the Act, the regulations and guidance notices issued by HIQA.
### Regulation 14: Persons in charge

The person in charge was recruited to her role in March 2015; the person in charge met the requirements of the regulations. Inspectors found that the person in charge had ready and sound knowledge of each resident. It was clear to inspectors that the person in charge had good oversight of the service and was consistently engaged in the governance, operational management and administration of the designated centre.

Judgment: Compliant

### Regulation 15: Staffing

It was unclear how often a required one-to-one time was available to a resident so as to support them in achieving their personal objectives and personal development. There was an associated risk assessment for inadequate one-to-one time; the risk scoring fluctuated and was most recently assessed and rated in December 2017 as of moderate risk.

Judgment: Substantially compliant

### Regulation 16: Training and staff development

All staff had not completed the safe administration of medicines training prior to commencing work in the centre. While inspectors were advised that all staff had completed training in the administration of a medicine required in response to a specific emergency, records to this effect were not maintained for all staff.

Judgment: Substantially compliant

### Regulation 23: Governance and management

There was a clearly defined management structure and persons participating in the management of the centre were clear on their respective roles, responsibilities and
reporting relationships. There were effective systems for the review of the quality and safety of the care and services provided to residents: reviews incorporated consultation with staff, residents and their families. Overall while actions did issue consistent good practice was evidenced and positive feedback was provided to the reviewer by those consulted with.

Judgment: Compliant

Quality and safety

While improvement was required, overall inspectors found that a safe quality service based on their needs was provided to residents.

Staff had completed comprehensive assessments of residents' needs. Plans of support were in place based on the findings of these assessments; residents' needs and plans were subjected to regular review by their key worker and the person in charge maintained oversight of the plan. Inspectors found the sample of personal plans they reviewed to be well presented, detailed, personalised and implemented in practice.

There was evidence that residents and their representative were consulted with and participated in the development and review of their plan. There was documentary evidence that each personal plan was the subject of a multidisciplinary review (MDT); records of these reviews were maintained including details of the action plan and responsible persons.

Each plan incorporated the process for the progression of residents' personal goals and objectives; records seen demonstrated the clarity of the sequential nature of this process. Inspectors saw that staff were in the process of identifying, agreeing and progressing with each resident their personal goals and objectives for 2018; there was a personal development theme to the agreed goals.

However, there was some evidence to suggest that there may have been insufficient staff resources to adequately support residents individual objectives; this was discussed in the first section of this report.

The provider had, prior to this inspection, identified that some residents' needs were not compatible across a group of houses in this locality; this incompatibility was impacting on both quality and safety. To address this, the provider made a decision to transition residents between centres with the objective of improving the quality and safety of all residents lives; the provider had advised HIQA of these plans. Therefore there was a clear rationale and objective, there was evidence of MDT discussion and input; there was evidence of staff input; the feedback provided to inspectors of the impact of the relatively recent transition of residents between
centres was positive. An inspection completed in the other designated centre after this inspection confirmed that overall the changes made were having a positive impact.

However, inspectors saw that the time frame for discussion and consultation with residents and their representatives was very brief; again staff provided a rationale for this related to some residents inability to successfully manage changes with a long lead in time. However this was not adequately evidenced to ensure compliance with Regulation 25 (3) and (4), (the transition and discharge of residents) or the provider’s own policy and procedure that stated the communication should commence well in advance of any actual move.

Residents were supported to maintain and enjoy good health and well-being; overall there was evidence of good care and practice. Staff consistently monitored resident well-being and sought medical advice and review from the general practitioner (GP) when necessary.

Where a health care need had been identified there was a corresponding plan of care, for example where residents required dietary modifications or experienced seizure activity. Staff maintained good records of referrals, reviews, recommended treatments and the care delivered to residents.

Overall as appropriate to their needs inspectors saw that residents had ready access to other health care services. The inspector saw that residents had access to neurology, psychiatry, psychology, behaviour specialist, speech and language therapy, dental care and chiropody. Nursing care if required was available from community nursing personnel. Health was promoted by access to national screening programmes, regular blood-profiling and annual influenza vaccination.

However, records seen stated and the person in charge confirmed that a resident did not have timely access to a service to which they had a statutory entitlement. Access to dietetic services had not been facilitated by the Health Service Executive (HSE) Community Services though the provider had requested access on the residents’ behalf.

There was documentary evidence that both residents and their representatives were consulted with and participated in decisions in relation to their care.

The provider had reviewed its policy and procedures for the management of medicines in September 2017. The provider had developed an enhanced programme of staff training in medicines management and was preparing to deliver this to staff.

Medicines were supplied to residents by two community-based pharmacists in their original container and in compliance aids. The provider supported the pharmacist to meet their obligations to the residents under their relevant legislation and guidance. For example the person in charge reported that residents went to the pharmacy to collect their medicines and were well known to each pharmacist.

Medicines were seen to be securely stored and overall were supplied on an individual resident basis. However, two over-the-counter medicines were seen to be
in stock that did not have a pharmacy issued label affixed to them.

Staff maintained a record of each medicine administered and the sample of medication administration records seen corresponded with the instructions of the prescription record. Improved practice was evidenced in that staff now recorded each individual medicine administered by them as opposed to recording as they had previously done that they had administered the blister pack.

Medicines management practice was the subject of regular audit by the person in charge. There were systems for managing any medicines incident; incidents were reviewed by the person in charge and corrective action was taken.

However, medicines were not always administered to residents as prescribed. A factor identified by the person in charge as contributing to these errors was failure by staff to review the prescription prior to administering medication. It was also of concern to inspectors that a staff had been allowed to administer medicines to residents without having completed safe administration of medicines training. This was not an appropriate practice and was not in keeping with the provider's own medicines management policy and procedures.

Some residents were supported to manage their own medicines. The inspector saw that this practice was supported by policy and an assessment of capacity and risk; monitoring procedures were implemented by staff to ensure ongoing resident compliance and capacity.

Residents did at times present with behaviours of concern and risk. There was evidence that residents had access to and support from psychiatry, psychology and behaviour support. There was evidence that strategies for responding to behaviours were informed by the monitoring and analysis of exhibited behaviours. Strategies were outlined in both risk assessments and in specific behaviour support guidelines; these were seen to be under review at the time of this inspection.

There was minimal usage of medication as an adjunct to the management of behaviour; medications that had been prescribed but not required were seen to have been discontinued during reviews. Staff did however consider triggers such as pain and did administer PRN (as required) pain-relief to alleviate and prevent a possible escalation of behaviours.

There were procedures for the identification, sanction and review of any practice deemed to have a restrictive impact on residents. These procedures were clearly implemented and there was evidence that residents were consulted with and agreed to the use of interventions such as devices to alert staff to seizure activity.

There were measures in place to protect residents from harm and abuse; these included organisational policies and procedures, a designated person, plans for the provision of personal care and staff training.

There was documentary evidence available to inspectors that staff recognised alleged abuse, understood the provider's reporting structure and action was taken as necessary to protect residents from harm and abuse; these actions were informed
by multidisciplinary consultation and discussion and any advice received from the local safeguarding office.

Residents’ knowledge and awareness of self-protection was supported through regular discussion at house meetings. The person in charge said that the majority of residents had the understanding and capacity to report any concerns that they had. If a resident could not express their concerns staff were attuned to any changes in demeanour or behaviour.

However, while the need to protect all residents from harm and abuse was evidently understood, clear explicit guidance to support safeguarding practice was required. The details of this were discussed with the person in charge and the area manager. This guidance was required to ensure that safeguarding measures referenced across a range of records seen including staff supervision and detailed record keeping were communicated to all staff and consistently implemented.

The risk register detailed the process for identifying, assessing and managing risks; there was an internal procedure for escalating risks that could not be managed or resolved locally.

Inspectors reviewed a range of completed risk assessments both centre and resident specific. These assessments indicated that the provider sought to promote and protect the safety of residents through this process of risk identification and management. The process of risk management was dynamic; risks were kept under review by the person in charge and were escalated appropriately to management. There was evidence of consultation on identified risks between the person in charge, management, quality and risk personnel and the multidisciplinary team (MDT).

However, at the time of this inspection there was a lack of organisational consensus as to the residual risk scoring attributed to some identified risks. There was a body of thought based on records seen and discussion with staff that some residual risk scores were too high; conversely there was opposing views that the high residual risk scoring was correct; this indicated to inspectors that there were differing views as to the adequacy of the existing control measures to manage and reduce the risk to resident safety and well-being.

Given the high residual risk scores and the lack of consensus on these, the provider was requested to prioritise the review of a pertinent risk assessment and provide confirmation to HIQA within a specified time frame as to the adequacy of the existing control measures. This was completed and adequate assurance on this specific risk was submitted to HIQA. However, the lack of consensus that had arisen required review and discussion to ensure that there were adequate systems and consistent guidance for staff on the assessment, management, and ongoing review of risk.

The designated centre comprised two houses. Neither house was equipped with emergency lighting or an automated fire detection system. Fire detection was dependent on battery operated smoke detectors. One bedroom was removed from the main sleeping area and situated adjacent to the main kitchen, utility area; there was no door between the utility and the hallway that acted as an escape route from
the bedroom.

The provider had given a commitment to HIQA that the appropriate fire safety measures would be installed in each house; however, the provider subsequently advised HIQA that these works could not be completed as the provider did not have the required financial resources available to it. This has been the subject of ongoing discussion with the provider and a plan has been submitted and agreed for a range of designated centres. Inspectors were advised that there was also a plan for addressing the fire safety deficits in this centre; confirmation is required that there is a time-bound, funded plan for this designated centre.

Fire safety measures including staff training in fire safety, the inspection of the fire safety interventions that were in place, the servicing of fire fighting equipment and simulated evacuation drills were all implemented in the designated centre; no deficits were found in these measures.

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**Regulation 25: Temporary absence, transition and discharge of residents**

When residents transitioned between services inspectors saw that the time frame for discussion and consultation with residents and their representatives was very brief.

Judgment: Substantially compliant

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**Regulation 26: Risk management procedures**

There was a lack of organisational consensus as to the residual risk scoring attributed to some identified risks.

Judgment: Substantially compliant

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**Regulation 28: Fire precautions**

Neither house was equipped with emergency lighting or an automated fire detection system. One bedroom was removed from the main sleeping area and situated adjacent to the main kitchen, utility area; there was no door between the utility and
the hallway that acted as an escape route from the bedroom. Inspectors were advised that there was a plan for addressing the fire safety deficits in this centre; confirmation is required that there is a time-bound, funded plan for this designated centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medicines were not always administered to residents as prescribed. Two over-the-counter medicines were seen to be in stock that did not have a pharmacy issued label affixed to them

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Staff had completed comprehensive assessments of residents' needs. Plans of support were in place based on the findings of these assessments; residents' needs and plans were subjected to regular review by their key worker and the person in charge maintained oversight of the plan. There was evidence that residents and their representative were consulted with and participated in the development and review of their plan. There was documentary evidence that each personal plan was the subject of a multidisciplinary review. Inspectors saw that staff were in the process of identifying, agreeing and progressing with each resident their personal goals and objectives for 2018.

Judgment: Compliant

Regulation 6: Health care

Access to dietetic services had not been facilitated by the HSE Community Services though the provider had requested access on the residents' behalf.

Judgment: Substantially compliant
### Regulation 7: Positive behavioural support

Residents did at times present with behaviours of concern and risk. There was evidence that residents had access to and support from psychiatry, psychology and behaviour support. There was evidence that strategies for responding to behaviours were evidence based. There were procedures for the identification, sanction and review of any practice deemed to have a restrictive impact on residents.

**Judgment:** Compliant

### Regulation 8: Protection

Explicit guidance to support safeguarding practice was required. This guidance was required to ensure that safeguarding measures referenced across a range of records seen including staff supervision and detailed record keeping were communicated to all staff and consistently implemented.

**Judgment:** Substantially compliant
## Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 25: Temporary absence, transition and discharge of residents</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 29: Medicines and pharmaceutical services</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Compliant</td>
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<tr>
<td>Regulation 8: Protection</td>
<td>Substantially compliant</td>
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</table>
Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action within a reasonable timeframe to come into compliance.
Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be SMART in nature. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tbody>
<tr>
<td>Regulation 15: Staffing</td>
<td>Substantially Compliant</td>
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</table>

Outline how you are going to come into compliance with Regulation 15: Staffing:

- Increased level of day service activities have been put in place for the individual to ensure greater choices and experience. In the residential house staff link up with other houses to afford the individual greater choice and experience. Likewise where any additional support hours are available, e.g. staff shadowing, these are used to afford the individual greater choice and experience.
- While the action is now complete and new controls have been put in place to support increased experiences for the individual, the risk, while reduced, will remain on the risk register for monitoring in line with the services risk management procedure to ensure the effectiveness of controls implemented in the long term.

| Regulation 16: Training and staff development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

- All staff have mandatory training completed including training for the safe administration of medication.
- SAMS training is currently being rolled out to all staff.
- Records for the administration of emergency medication have been updated.
Regulation 25: Temporary absence, transition and discharge of residents

Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:

- The timeframe for discussion and consultation with residents and their representatives was brief due to some resident's inability to manage the changes with a long lead in time. The delay in consulting with residents has been evidenced as such.

- In any future transition of residents, adequate evidence will be on file to identify any anxieties or potential issues and ensure compliance.

Regulation 26: Risk management procedures

Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

On the 20/02/2018, organisational consensus was reached as to the residual risk scoring. The risk was reviewed by the MDT, Head of Community Services and Head of Quality and Risk.

Regulation 28: Fire precautions

Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

In addressing the fire safety deficits in the Centre, emergency lighting and automated fire detection systems are currently being installed in both houses. A fire door is also being fitted between the utility room and the hallway that is an escape route in one house. The current works will be completed by 30th July 2018.

Regulation 29: Medicines and pharmaceutical services

Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Medication errors occurred with incorrect documentation as staff were not reviewing the Kardex prior to administering medication. This issue has been discussed on an ongoing basis with the relevant staff and at staff meetings. Other medication errors were made on home visits. The PIC has discussed with families re correct administration of medication.

• All staff have medication training and SAMS training is currently being rolled out to all staff.

• All medication in stock has a pharmacy label affixed.

• Any medication not prescribed, i.e. over-the-counter medication, is only administered after consultation with the pharmacist who has reviewed the Kardex of the person to whom the medication is being prescribed. Administration is recorded as per policy.


Regulation 6: Health care  Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• Dietetic Services were not facilitated for one resident while waiting for Community Services to facilitate. A review by the Speech and Language Therapist decided dietetic services were not required on the 23/05/2018.

• The local Personal Assets policy was reviewed on the 16/01/2018, giving guidance to staff re the purchasing of private appointments from service-users personal assets when services are not facilitated by the Health Service Executive Community Services. The decision to purchase private appointments is made in consultation with the MDT team, Area Manager, Head of Community Services and the individual.

Regulation 8: Protection  Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A support plan to ensure that safeguarding measures referenced across a range of records, including staff supervision and detailed record-keeping was implemented to provide guidance for staff on the 05/03/2018.

• The plan was reviewed and assessed as comprehensive and clearly outlining the mitigations in place by the Head of Quality and Risk on the 15/03/2018.

• The plan was also reviewed by the MDT team on the 20/03/2018 and also on the 22/05/2018. A recommendation was made for a referral for Social Work support.

• Further to this recommendation An MDT meeting took place on the 01/06/2018. Recommendations of the meeting have been reviewed by staff.

• Ongoing monitoring of residents is being recorded on a daily basis as per Support Plan. Support is being provided by all staff.

• Further MDT and meetings with Social Work and Psychology are scheduled in June 2018.
Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15(1)</td>
<td>The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>8th June 2018</td>
</tr>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30th June 2018</td>
</tr>
<tr>
<td>Regulation 25(4)(d)</td>
<td>The person in charge shall ensure that the discharge of a</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>8th June 2018</td>
</tr>
</tbody>
</table>
resident from the designated centre is discussed, planned for and agreed with the resident and, where appropriate, with the resident’s representative.

**Regulation 26(2)**
The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

<table>
<thead>
<tr>
<th>Substantially Compliant</th>
<th>Yellow</th>
<th>8th June 2018</th>
</tr>
</thead>
</table>

**Regulation 28(2)(c)**
The registered provider shall provide adequate means of escape, including emergency lighting.

<table>
<thead>
<tr>
<th>Not Compliant</th>
<th>Orange</th>
<th>30th July 2018</th>
</tr>
</thead>
</table>

**Regulation 28(3)(a)**
The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.

<table>
<thead>
<tr>
<th>Not Compliant</th>
<th>Orange</th>
<th>30th July 2018</th>
</tr>
</thead>
</table>

**Regulation 29(4)(b)**
The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration.

<table>
<thead>
<tr>
<th>Substantially Compliant</th>
<th>Yellow</th>
<th>8th June 2018</th>
</tr>
</thead>
</table>
of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

<table>
<thead>
<tr>
<th>Regulation 06(2)(d)</th>
<th>The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.</th>
<th>Substantially Compliant</th>
<th>Yellow</th>
<th>23rd May 2018</th>
</tr>
</thead>
</table>

| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 1st June 2018 |